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Spiritual Needs as Experienced by Muslim Patients in Iran: A Qualitative Study

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Abstract: Until the last 2 decades, spiritual care was a vital, but invisible, aspect of nursing care. Spirituality and spiritual care have entered the mainstream and the literature in this area has burgeoned. In addition, there is minimal information in the literature documenting the expressed spiritual needs of patients in general and specific subgroups of patients in particular, thus this study aimed to present spiritual needs of Iranian Muslim patients. Therefore, this study is of significance to nursing in general and to transcultural nursing in particular because of the high priority associated with increasing the nursing knowledge through research that investigates and describes care practices in diverse cultures. This study reports an investigation into the spiritual needs of hospitalized Iranian Muslim patients. A qualitative study with a sample of 24 patients using semi-structured interviews. The sample selected from three different cities of Iran. Although not clearly distinguishable, we found two main spiritual needs include religious and existential needs in Iranian Muslim patients. With regard to holistic approach in Islamic philosophy, holism is a relevant concept in the care of Iranian patients.

Key words: Spiritual need, religious need, spiritual care, holistic care, Muslim, Iran

INTRODUCTION

Until the last 2 decades, spiritual care was a vital, but invisible, aspect of nursing care. Certainly, it was not a prominent area of discussion or debate in the mainstream nursing literature. But now spirituality and spiritual care have entered the mainstream and the literature in this area has burgeoned. Wright's argument about the ethical responsibility of nurses to care for the spiritual needs of patients is now widely accepted (Wright, 1998).

Accreditation criteria (JCAHO) is recognizing the spiritual dimension of healthcare. Although some nurses responsible for delivering the care might feel uncomfortable implementing it, there is consensus in the literature that it is an essential part of care. The argument for spiritual care generally goes as follows: The spiritual is a universal dimension of the person and healthcare disciplines have a responsibility to provide holistic care; therefore, healthcare workers have an ethical responsibility to provide spiritual care, the neglect of which would be neglecting a fundamental obligation.

There has been a tendency in the spiritual care literature to construct a spiritual discourse that represents a preferred vision for the evolution of the profession, a vision that may not always be congruent with what research has suggested patients want from nurses in the area of spiritual care (Taylor and Mamier, 2005). The perpetual temptation of nursing will be to adopt a normative disciplinary discourse as it relates to the nature of the spiritual to serve disciplinary ends, particularly during a time when nursing continues to struggle to define its ontology. However, nurses have a foundational ethical responsibility to ensure that spiritual care is constructed in such a way that precedence is given to preserving the dignity and choices of patients to maintain their own diverse worldviews in the context of healthcare.

In addition, there is minimal information in the literature documenting the expressed spiritual needs of patients in general and specific subgroups of patients in particular. Although some studies identify spiritual needs (Charters, 1999; Conner and Eller, 2004; Narayanasamy *et al*., 2004; Frick *et al*., 2006) and spiritual nursing interventions (Reed, 1991b; Sellers and Haag, 1998) but the applicability of these to other cultures such as Iranian Muslim population is unknown.

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Therefore, this study is of significance to nursing in general and to transcultural nursing in particular because of the high priority associated with increasing the nursing knowledge through research that investigates and describes care practices in diverse cultures.

To gain access to patients' experiences, qualitative research was conducted using open interviews.

Spirituality is the propensity to make meaning through intrapersonal, interpersonal and transpersonal relationships that empower the individual (Reed, 1992). It is an empirical indicator of the ability of humans to transcend (Reed, 1987). There is a host of critical analysis of the concept of spirituality in the nursing literature. Religion, as a concept, is perceived by many (in the West) as not being interchangeable with spirituality. In this context, the concept of spirituality has a broader meaning than religion and encompasses philosophical ideas about life, its meaning and purpose (Harrison, 1993; Dyson *et al*., 1997). According to Wright (1999) spirituality can be seen as the summation of our values which determines the process of how we interact with the world; whereas religion is seen as a pathway to follow the practices and thoughts that are appropriate to the god or gods of a particular faith.

Cited in Mcsherry (2000) Stoll writing from the Judeo-Christian tradition, identify two dimensions of spirituality: vertical and horizontal dimensions. The vertical dimension-that is the individual's relationship with the transcendent (God, Supreme Being or supreme values) and the horizontal dimension of the relationship with oneself, other people and the natural world. However, in Islam and following the Holy Qur'an and Hadiths (Sayings, deeds or agreements of the Holy Prophet), there is no distinction between religion and spirituality. The concept of religion is embedded in the umbrella of spirituality. In the Islamic context, there is no spirituality without religious thoughts and practices and the religion provides the spiritual path for salvation and a way of life. Muslims embrace the acceptance of the Divine and they seek `meaning, purpose and happiness' in worldly life and the hereafter. This is achieved through the belief in the `Oneness of Allah', without any partner and the understanding and application of Qur'anic practices and the guidance of the Holy Prophet (PBUH). The material realm of this world is given `in trust' from Allah.

In this model, Allah's unity must be maintained spiritually, intellectually and practically in all facets of human life. Philips (1994) maintains that monotheism, as brought by the prophets of God, was not merely a theory to be philosophically appreciated or emotionally championed, but a pragmatic blueprint for human existence in submission to the will of almighty God, Allah.

According to Rahman (1980) the spiritual discipline "`which educates and trains the inner self of man" is the core of the Islamic system. It also frees man from the slavery of the `self', purges his soul from the lust of materialistic life and instills in humans a passion of love for Allah. It is through the process of patience, perseverance and gratitude that opens the door for spiritual and physical well-being" (Rassool, 2000)

Islam is a faith that has in excess of 1.3 billion followers in the world (Sheikh and Gatrad, 2002) and Muslims form the largest non-Christian religious group. Muslims are found throughout the world. Although there are Muslim minorities in almost every country, they are most numerous in the Russian federation, India and central Africa. There are about 15 million Muslims living in Europe and about 7-8 million in the United States. While the practices of Muslims may differ in various parts of the world, especially in terms of orthodoxy, they are connected by their common Islamic faith and heritage.

Iran is a large country in the Middle East. The present population is approximately 65.5 million and is estimated by the United Nations Information Centre to soon surpass 70 million people (United Nations Information Centre, 2005).

Since the Iranian Revolution of 1979, millions of Persian speaking peoples from different faiths have migrated to other parts of the Middle East, to the US, Europe and other areas of the world. According to the Persian Diaspora Census, up to 1996, the total number of migrated people had been 4167 000 (Persian World Outreach, 2005).

MATERIALS AND METHODS

The purpose of this investigation is to explore the spiritual needs of Muslim patients in the Islamic context of Iran. Participants in this study were patients selected from the population of inpatients in hospitals of Iranian cities for 10-monthes period from June 2006 to April 2007. Participants selected from 3 different cities for catching maximum variation. Patients were included in our study had following characteristics: They was volunteer to take part in the study; they were 18 years of age or older; their hospitalization duration was longer than 3 days; their condition was not so severe that they could not participate in interview and they had no severe mental disorders or dementia. Total 24 patients participated in the study and 27 interviews have done. After providing

detailed information on the purpose of the study, informed consent signed by patients. Open sampling was used and no specific demographic features or length of stay were sought when obtaining participants.

Permission to carry out the study was obtained from the university research deputy. Participants were given information about the purpose of the study, the voluntary nature of participation and assurances that anonymity and confidentiality would be maintained.

Interviews that conducted in hospital were audiotaped and questions were asked to encourage patients' responses in a narrative form. The questions related to their experiences of spiritual needs and spiritual care they want to. Interviews were transcribed and open coding system was used to generate preliminary categories.

Open coding stage involved reading the transcriptions several times and underlining common or salient themes. These were then given a title, either a term used by the patients or one generated by the researchers. Then some of participants were interviewed again to discuss the interview transcripts and the main themes that arose.

RESULTS

At the end of analysis process, two main categories were generated: Religious needs and existential needs.

We have given some narratives from interviews for easy audit:

> I have been here since three days ago, I didn't pray anyway, I 'm so sad about that, tell them to give me clean trousers.

Codes that we extracted from this excerpt include:

- Need to pray
- Need clean clothes

Another example:

> When I am frail and I cannot pray, I talk (friendly) with god, I say "my god, are you ok, what did you do today? Did you have a nice day?" I have a better sense with this conversation than usual prayer. I feel friendly with god.

Codes that related to this narrative comprise:

- Need to connect to god
- Talking friendly to god
- Need good feeling

Table 1: Sample of codes level one and two in inductive method

Codes level 1	Codes level 2
Feeling comfort near the family	
Feeling calm after visiting children	
Sense of uneasy because of prohibited visiting	Communication
Loneliness in absence of companion	
Feeling a need to have companion	
Feeling ashamed for wanting help from nurses	Companion
Need talk to god	
Need to prayer	
Discomfort incases which can not pray	Connectedness with sacred
Feeling soothe after talking	
Feeling need to have someone for listening	
Rising mood after talking	Conversation

List of codes that categorized in next steps are shown in Table 1.

We described level two codes:

Worship: Expectedly religious needs had high priority for patients and most of them felt need to worship (prayer (Salah), zikr, reading Qur'an, praying (Doa) and fasting) while hospitalized in hospitals. The needs for doing worship were purity (Taharah), worship utensils, religious songs (Adan) and religious specialist. Purity was the highest felt need by Muslim (Shia) patients. Purity was about cleanliness of body, clothes and the place of prayer as illustrated by the following excerpt from the interviews.

> There is (venous catheter) on my hand so I can't do taiammum (dry cleaning), the tapes are bloody so I can't do ablution; tell me what can I do?!

The second most felt need for doing worship was worship utensils include cachet, clean rug, sign of direction of qibla, food for fasting (sahary and iftar), Qur'an and other religious books with large fonts, rosary and clean water or sand for ablution. The following are sample statements:

> If they give a clean carpet, put a cachet and show direction of qibla, I can pray.

Connectedness with sacred: All of patients mentioned that the ultimate purpose of worship is feeling connectedness with god and religious leaders (prophet and Imams) but the worship is not the only way to this aim. They can reach this goal with other ways like giving service to people or connectedness with nature. As one of participants confirmed in this regard:

> Prayer is not the only way to connect with god, smelling a flower is another way because it is the creature of the same god.

Religious resources: The last but not least religious needs of patients were feeling to have powerful supporter

or religious resources. These resources include god, prophet, imams and qoran as illustrated by one participant who stated:

> Trust, I say to kids, there is no means for life without trust, in every thing. Can you predict future life for yourself or for your husband? Every thing is dependent on him (God). If he wants, the drug will affect, otherwise wont. When he (God) will, he puts in their (doctors) mind what should they do for me. The drug will affect if god wants to treat the patient.

Other patient acknowledged:

> Anything I have is from my faith to god. How can you assure your future without faith in god? Surely, it is impossible without believing in god, without 14 innocents (Prophet, her daughter and 12 Imams of Shia); there is no mean for life in my view. Hope is good but these sacred are the source of hope. Then, with obeying their orders, we will be hopeful. We will be sure that we have a supporter in this world. There is any mean to live without Imam Asr (last Imam of Shia, he is alive and will come to save people of world), is there?.

The above codes were categorized as religious needs.

And the other needs (below) were categorized as existential needs.

Communication: Communication is the head of existential needs. Patients need to communicate with nurse, doctors, family (parents, spouse, children and siblings), relatives and neighbors. These communications have strong effect on physical and spiritual state of patients as illustrated by a patient:

> If my family didn't support me, I wouldn't tolerate the disease. Illness is hard, but not supporting family is harder. Family solidarity helped me very much. If I didn't sure about my children, I couldn't stay here for a while.

A great deal of frustration and pressure was expressed by the patient's companions because of the lack of communication with health care team. This need illustrated in the following interview excerpt.

> Nurses have not a suitable communication with patients…they are good with each other but not with patients… communication has great effect. Drug may have not effect on patient, communication, a chat have more effect than a pill of acetaminophen to headache. Nurses talk with each other well, but in the case of us, only one word. They don't give a chance to talking patient or his (her) companion.

Conversation: Patients uttered their need to conversation and not merely doing job by nurses. The conversation is a way to trustful communication and feeling light.

> "My expectation is that, they (nurses) attend, talk and laugh, not to merely give the usual care and go. Some do in this manner, come, just do their work with their heads below and go, but some are good, have conversation with patient ,talk about their job, one of nurses talked with me….it was good, so when she come, we laugh, we talk, it makes a good climate, I don't feel being in hospital. I feel peace in this manner….excuse me, I feel light when I talk".

Physical care: Because of inseparability of human dimensions (spiritual, physical, psychological and social) inadequacies in physical care, including pain control, basic care and adequate treatment can lead to spiritual distress and anger. This claim supported by following declarations:

> I am in trouble, I can't pray, I have foot pain, I thought to pray in lying position at least with taiammum (dry cleaning), but I couldn't. I need to some analgesic.

Attention and presence: Patients needed to perceive empathy and a caring attitude through the words, actions and body language of health care providers and sharing personal experiences and opinions and displaying emotional warmth by them.

> I have been here since three days ago hungry and thirsty…I say, look to me (attend), when I'll be operated, but they don't see me.
>
> I think there is not fire in hell, if you were put in there lonely, have not anyone to caring and don't see anyone, it's the true hell.

Meaning and purpose: The pain and disease often intensified patients' search for meaning and purpose to their own suffering. Meaning and purpose was searched by looking back to past to find any guilt that may contribute to punishing them by God. A patient with end stage renal disease who has tolerated dialysis since three years ago whispered:

> I don't know why I must suffer as so much, I look to the past to find the cause of this pain, what I did to tolerate this suffering but I don't find anything.

Companion: Companionship of family member was the will of most patients. They wanted companion for doing their basic cares, listening to their conversations and helping them in worship. In addition, they wanted to feel a person presence near them. For example, one patient said:

> If I have not companion, I'll be in trouble because of loneliness. I seem good but until yesterday I needed them (companions), all of my caring is done by them.
>
> Because I had severe pain, I get some anxiety, I took the hand of my son who was with me in that time, I thought I would had a better sense if all of my kids were near me.

Peace: Assessing feeling peace by patients is fundamental in spiritual assessment and in this study, some of patients expressed their genuine need for peace. An example brought here:

> I don't feel peace anyway, I asked doctor to write a drug for me.
>
> When I pray, I feel peaceful, I get empty (of sorrow), so I care about time of prayer.

Certainty: Uncertainty, i.e., not knowing the meaning of life, is the cause of the sense of meaninglessness associated with spiritual pain. The intensity of such pain evokes a negative perception of meaninglessness which has been labelled 'spiritual pain of meaninglessness as one of patients expressed hesitated:

> I don't sure about the view of god about me. There is no one to give response to this demand. I rely on god but I don't know if he accept me or not, I say god but there is no sound from him.

Hope: The main spiritual need for some of participants included giving hope by the nurses about getting well and freeing them from worrisome. One participant claimed:

> If I was a nurse, I sat near the patient and say, don't worry, you'll get well.

Transcendence: The true nature of spirituality is the need to transcendence, going beyond materiality of universe, so if patients have opportunity to meet her basic needs they will experience this need. One of patients experienced this and acknowledged:

> I like to have great patience, as if I have world's entire problem, I can tolerate.

Privacy: In the Iranian culture, privacy includes modesty (hijab), separation of men and women, caring by same sex and a private place for worship. Modesty is very important for both sexes but especially so for women.

> If I had remedy, I wouldn't stay here (hospital), no prayer, no modesty (hijab), men come to ward. No one had seen my hair until now.
>
> The main problem if you keen to solve is this toilet. They have two toilets for entire ward. Men and women go to same toilet. Toilets must be separate for men and women. This is most important.

Knowledge: Patients described knowledge as the need for accurate understanding of their condition. Lack of knowledge was a source of anger and frustration for them. For example:

> If they say the diagnosis (cancer), patient can manage herself, she can do well for herself, right, it's very hard at first but we can adapt very soon. Nevertheless, we will be worried all the time.

Knowledge can be achieved through truthful communication and is one factor that can contribute to truth in being. Truth in being is a process by which a patient's perceptions and experiences become congruent with the reality of the diagnosis (i.e., cancer diagnosis).

Patients wanted to be informed about their disease and treatment.

> It is good to have appropriate communication, when we see doctor we fray, for example I afraid to ask for (blood) pressure pill…we should have ability to asking our question.

Categories have been resulted from the codes level two have shown in Table 2:

As mentioned earlier we stratified the above needs in two main categories include religious needs and existential needs as shown in Table 2.

Table 2: The spiritual needs of Iranian Muslim patients

Codes level 2	Themes
Connectedness with sacred	1. Religious needs
Religious supporter	
Worship	
Attention and presence	2. Existential needs
Meaning and purpose	
Communication	
Transcendence	
Conversation	
Physical care	
Knowledge	
Companion	
Certainty	
Privacy	
Peace	
Hope	

DISCUSSION

Expectedly the most prominent spiritual need described by Iranian Muslim patients was worship. Worship plays a major rule in the living of Muslim patients. Daily prayer facing toward the holy city of Mecca in Saudi Arabia is a basic Islamic belief. The first prayer of the day is before sunrise and the final prayer is an hour after sunset. Prayer is the ceremonial recitation of prescribed words in Arabic accompanied by different body positions from standing to kneeling with the head to the floor. Prayers can be performed anywhere. To help maintain cleanliness, the floor is covered by a prayer rug or other clean piece of material (Lawrence and Rozmus, 2001).

It is very irritating that the most of patients in this study reported their inability to pray in the hospital, while illness is a time of crisis that one is often forced to look deep within to find meaning in the midst of suffering and connecting to God (through worship) can facilitate this process. Spirituality can be particularly important in coping with a serious illness and the relevance of religion and spirituality to patients, especially patients with life-threatening disease, cannot be over looked within our health care institutions.

The importance of religious practices was found in Halligan's (2006) study of nurses' experiences in care for Muslim patients who, stated: "The role of religion was viewed as all encompassing. The influence of Islam was evident in all of the narratives and appeared to be intertwined in every aspect of patient care". As well, Conner and Eller (2004) study found connectedness with god as a spiritual need in Christian African Americans. Muslims believe that prayer (salat) is the best among all acts of worship if it is accepted by the Almighty Allah, other acts of worship are also accepted. And, if prayers are not accepted, other acts are also not accepted. Offering of prayers five times during day and night makes our body clean of al filth and dirt. It is befitting that one should offer prayers punctually (Lankarany, 2007).

The other most stated spiritual need of patients is communication, especially with family and companion is very important to the most patients who offer care and support to them. The need for companion is mentioned in Joolaee (2006). The participants emphasized that the presence of their companion was an extremely important factor in providing and protecting their rights. They want to have a companion because they are fully aware that not having one would inevitably result in their most basic needs not being met while on the ward. Should they require anything to be obtained from outside the hospital, such as medication or disposable equipment, their companion is the only person who could be relied upon to provide them with this service.

The importance of communication with family is also found in Omeri's (1997) study of care meanings, expressions and practices of Iranian Muslim immigrants in Australia. As indicated in the present study, family visiting and support (emotional, social and physical) are important ways of 'being together'. Followers of Islam are obliged to visit a person and to enquire about their health (Johnson, 2001). So the real need of patient is to allow the patient have companion and a large number of visitors, although it may seem disrupting to nursing duties.

These findings support current initiatives for policy change that favor unrestricted visiting in hospitals and family presence on bedside during their patient's hospitalization.

Many of the identified themes have been used by other disciplines that seek to describe human nature such as psychology, sociology and anthropology; however, it is important to recognize that these themes are also vehicles for spiritual expression. Spiritual themes such as hope, communication, attention, presence and knowledge, sense of power, joy, support and certainty represent the desired attributes of health care providers' interactions with patients. Communication imparts awareness and understanding of the meaning and significance of the information to the patient. Physicians and staff can establish communication through availability, words, tone of voice, attentive listening, expressed emotion and appropriate timing.

Lake of truthful communication with staff leads to feeling a great deal of anger by patients. In addition, Patient's anger arises from feelings of powerlessness and a sense of frustration. Anger is often misdirected toward self, others, or God, in the form of blame. Anger and blame are attempts to make sense of a senseless situation.

Patients used the phrase "just doing their job" to denote detachment, aloofness and aggression. A good communication needs to place one's confidence in another. Truthful communication and compassion engenders trust in health care providers. Communication develops through a series of interactions and events in

which health care providers' consistently demonstrate reliability, integrity and genuine concern for the patient's welfare.

Our findings suggest that patients have intense spiritual needs at the time of hospitalization.

Patients' spiritual needs presented with religious and nonreligious languages and behaviors. Spiritual needs are met in the context of relationships. Health care providers can help to support parents' spiritual needs through their daily conversations and interactions. Words and actions that demonstrate a caring presence, impart truth and fostering trust will help support parents' spirituality as they work through the experience of their hospitalization. Health care professionals can also support patients' spiritual needs by providing ample opportunity to stay connected with their family by having companion. Such practices can be viewed as a healing act that health care providers can offer to distressed patients.

One of patients' spiritual needs is privacy that is mentioned by patients. This need may meet in Iran somewhat because of its Islamic culture and government; however, its consideration is very important in western country. The privacy is not only including modesty but also being cared by the same sex and in a closed room and having a close companion with the same sex.

Worth noting that none of patients mentioned the need to religious accepted foods (Halal), because in Iran all foods provided in religious manner and they do not feel this need. However, as mentioned by Leininger and McFarland (2006) nurses should consider these needs if they want to do a culture competent care.

Although we have categorized the themes in two main categories, there is an overlap between these needs. For example, one of existential needs is hope but Muslim patients gain their hope mostly from religious supporters (God, Prophet and Imams) that belong to religious needs. For another example Iranian Muslim patients gain their peace (existential need) through worship (spiritual need). This is congruent with the holistic view of Islam that considers all dimensions of human simultaneously as stated by Rassool (2000).

CONCLUSION

Concerning findings, it can be argued that holism is an appropriate concept in caring for Iranian Muslim patients. The study highlighted met and unmet spiritual needs of patients and explored the relatedness of these needs to holism, philosophical basis of Islamic life.

Implications for practice: Regarding the need to worship it is best that nurses and other health care providers talk about this and remove the barriers of prayer. i.e.: A prayer room for Muslims may be provided. The room should be quiet, clean and carpeted. Access to washing facilities is necessary.

For Muslims, there are obligatory prayers that are performed five times a day at designated times. This is believed to be a direct link between the worshipper and Allah.

If possible, a relationship with an Imam or community faith leader should be established that could serve as a religious resource.

Health care providers should consult with patients for prayer time and be sure that there is not interference between prayer time and rounds and health care services.

Any prayer take only 15 min but providing private place and time is very important. I.e. placing a note on door for requesting privacy in the prayer time allows patients do prayers.

Nurse can support the prayer of patient. Support can be done be done with respecting to calm and private time. In addition, nurse can help patient to make ablution or read qoran for her and be sure about cleanliness of clothes and prayer place.

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